Clear Form

MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME

As of 1 Jan 2020

APPLICANT INFORMATION

Veterans Name:			
Date of birth:	SSN:	Phone:	
Physical address:	City:	State:	Zip:
Mailing address:	City:	State	Zip:
Date(s) of Military Service:	Character of Discharge:	Please Submit Verification (DD214)	

Married ◯ Single ◯ Divorced ◯ Widow/Widower ◯ Never Married ◯ Separated

Spouse Name:	
Date of Birth:	SSN:

IN CASE OF EMERGENCY CONTACT INFORMATION

Name:	Relationship:
Address:	
Home Phone:	Cell Phone:

NEXT OF KIN CONTACT INFORMATION

Name:	Relationship:
Address:	
Home Number:	Cell Number:

LEVEL OF CARE/MEDICAL INFORMATION

Level of Care Sought (select one): ◯ Residential Living (Independent) ◯ Nursing Care

Criteria for Residential Living:

- General health status is stable and does not require frequent medical Interventions for a Physician, Physician Assistant, or Certified Nurse Practitioner
- Free of communicable disease
- Residential living requires that potential residents have total independence with personal care needs; such as, bathing, dressing, eating, ambulating (walking), toileting, transferring, etc.
- Applicants who have a diagnosis of alcohol or substance abuse must have twelve months of documented sobriety before being accepted to the SDVH

Criteria for Nursing Care:

- The applicant requires nursing care 24 hours per day.
- The applicant requires nursing staff to manage, observe, and evaluate care.
- The applicant requires supervision or monitoring to ensure his or her safety.
- The applicant may require nursing restorative services and / or therapy rehabilitation services.
- Applicants who have a diagnosis of alcohol or substance abuse must have twelve months of documented sobriety before being accepted to the SDVH.
- PASRR (Pre-Admission Screening and Resident Review) Required

List all major medical conditions:

Are you compensated by the Department of Veterans Affairs for a service-connected Disability? ◯ Yes ◯ No

If yes, Compensation Percentage: %

Cost of Care for the Michael J. Fitzmaurice South Dakota Veterans Home

Residential Living (Independent)	Nursing Care
Assets above $50,000 rate is $181 per day (**Approximate Cost: $5,505.42 per month based on Calendar Year 2020 rates)**	$329.00 per day (**Approximate Cost: $10,007.08 per month based on Calendar Year 2020 rates)**
Assets below $50,000 is 50% of total income (single) 55% of total income (couple)	

MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME

APPLICANT INFORMATION

Veterans Name:	Preferred Name:
Mother's Maiden Name:	
Birth Sex: ◯ Male ◯ Female	
Are you Hispanic or Latino: ◯ Yes ◯ No	
What is your race? (You may check more than one): ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander	
Birth City:	Religion:

MILITARY SERVICE INFORMATION

Last branch of service:	Last Entry Date:	Future Discharge Date:	Last Discharge Date:
Discharge Type:		Military Service Number:	

Military History (select those that apply):

- ☐ Are you a Purple Heart Recipient?
- ☐ Are you a former prisoner of war?
- ☐ Did you serve in a combat theater of operations after 11/11/98?
- ☐ Were you discharged or retired from military for a disability incurred in the line of duty?
- ☐ Are you receiving disability retirement pay instead of VA compensation?
- ☐ Did you serve in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998?
- ☐ Do you have a VA Service-Connected Rating? If yes, what percentage? _____%
- ☐ Did you serve in Vietnam between January 9, 1962 and May 7, 1975?
- ☐ Were you exposed to radiation while in the military?
- ☐ Did you receive nose and throat radium treatments while in the military?
- ☐ Did you serve on active duty at least 30 days at Camp Lejeune from August 1, 1953 through December 31, 1987?

Signatures

I certify that the information contained above is true and correct to the best of my knowledge. My signature, or the signature of my representative, signifies my interest in admission to the Michael J. Fitzmaurice South Dakota Veterans Home. I agree to cooperate fully with providing additional admissions documentation that is necessary prior to admission to the Michael J. Fitzmaurice South Dakota State Veterans Home.

Signature of Application or Representative (required):	Date:
Signature of Spouse (if applicable):	Date:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

Name _____ Date of Birth _____

I hereby authorize *Michael J. Fitzmaurice South Dakota Veterans Home 2500 Minnekahta Ave. Hot Springs, SD 57747* to release my Protected Health Information as described below:

Name (please Print)	**Relationship & phone number**	**Medical**	**In Person**	**By Phone**	**Email**	**Email Address if applicable**
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	

Information to be released (check each requested item)

History and Physical ☐ **Progress Notes** ☐ **Soc. Worker Notes** ☐

Laboratory Reports ☐ **Radiology Reports** ☐ **Other** ☐

Other is specified as: _____

The following information will not be released unless you specifically authorize it by checking the relevant box(es) below:

☐ **I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment**

☐ **I specifically authorize the release of information pertaining to mental health diagnosis or treatment**

The purpose of this release is (check one or more)

☐ Continuity of care or discharge planning

☐ At the request of the resident/resident's representative

☐ Other (state reason) _____

Expiration of Authorization: Unless otherwise revoked, in writing, this authorization expires at the time I am no longer a resident at the Michael J. Fitzmaurice South Dakota Veterans Home.

_____

Signature of Resident or Resident Representative Date

_____ _____

Printed Name Resident Representative Relationship

NOTICE: Michael J. Fitzmaurice South Dakota Veterans Home and many other organization and individuals, such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect it.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the Michael J. Fitzmaurice South Dakota Veterans Home at 2500 Minnekahta Avenue, Hot Springs, SD 57747. The revocation will take effect when the Michael J. Fitzmaurice South Dakota Veterans Home receives it, except to the extent that the Michael J. Fitzmaurice South Dakota Veterans Home or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

AUTHORIZATION FOR FINANCIAL VERIFICATION

I HEREBY AUTHORIZE THE VETERANS ADMINISTRATION AND ANY BANK, SAVINGS AND LOAN OR OTHER FINANCIAL INSTITUTION TO RELEASE TO ANY AGENT OR REPRESENTATIVE OF THE MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME A FINANCIAL STATEMENT OR OTHER FINANCIAL INFORMATION REGARDING ALL ASSETS, INCLUDING PROPERTY, ACCOUNTS, LOANS, AND INVESTMENTS, IN WHICH I OR MY SPOUSE HAVE AN INTEREST.

- **SUCH AUTHORIZATION IS CONTINUING AND WITHOUT LIMITATION FROM THIS DATE.**

DATED THIS_____DAY OF_____, 20___.

_____
(APPLICANT)

_____
(NOTARY PUBLIC)

SEAL

COMMISSION EXPIRES_____

The following summary is provided to help you understand the laws that refer to disposition of assets while residing at the South Dakota Veterans Home.

- There often is a difference between what you will pay as your monthly maintenance rent and the actual full cost of care. South Dakota Codified Laws provide for a claim against your estate up to the amount of that difference.
- The specific laws are reprinted below. We recommend that you share a copy of this information with your next of kin.
- If you have any questions, please feel free to contact the Veterans Home Business Office at (605) 745-5127.

SDCL 33A-4-16. Distribution of assets of deceased member. If any member of the State Veterans' Home dies without legal dependents, the member's property shall be distributed to the South Dakota State Veterans' Home as sole heir for the sole use and benefit of the home. The member may, by will, dispose of the member's estate subject to the preferred claim provided in §§ 33A-4-17 to 33A-4-20, inclusive. A spouse residing at the home is considered as a legal dependent for the purpose of this section.

SDCL 33A-4-17. Authority to turn deceased member's property over to department--Subsequent claim for property. If a member of the State Veterans' Home dies, leaving at the home cash or other personal property of value, the superintendent of the home may turn over the cash, property, or its proceeds to the Department of Veterans Affairs for the sole use and benefit of the home, without administration. The cash, property, and proceeds are subject to refund within three years to any creditor, legal dependent, or heir, if the deceased member left a will, and if the creditor, legal dependent, or heir establishes a right to the cash, property, or proceeds or any portion of the cash, property, or proceeds. The attorney general, upon being satisfied that a claim out of the cash, property, or proceeds is legal and valid, may certify the claim to the secretary of veterans affairs, and the secretary of veterans affairs shall satisfy the claim.

SDCL 33A-4-18. Claim for maintenance of deceased member--Disposition of funds. If an estate is left by a deceased member of the State Veterans' Home leaving no surviving spouse or dependent, the state home shall file a claim against the estate of the deceased member in the amount of the full maintenance charge for each month the member was in the home, retroactive from the date of admission with proper credits allowed to the estate of the deceased member for any payments made by the member. However, the credits may not include any allowances of the state government. Any such money received from the deceased member shall go to a capital fund of the state home for repairs, equipment, improvements, or construction.

SDCL 33A-4-19. Claim against estate of deceased spouse or dependent. If a deceased member of the State Veterans' Home leaves a spouse, or other dependent, the member's estate is payable to the spouse, or other dependent. Upon the death of the spouse or other dependent, the state home shall file a claim against the estate of the deceased spouse or other dependent for any claim against the estate of both the deceased husband and wife as provided in § 33A-4-18. The claim is a preferred claim against the estates.

SDCL 33A-4-20. Transfers to avoid state's claim. Any transfer of property to avoid the payment of a claim of the State Veterans' Home shall be voidable.

SDCL 29A-6-107 Payment to surviving party from multiple-party account -- Liability for debts and expenses of administration -- Procedure -- Liability of financial institution. No multiple-party account is effective against an estate of a deceased party to transfer to a survivor sums needed to pay debts, taxes, and expenses of administration, including statutory allowances to the surviving spouse, minor children and dependent children, if other assets of the estate are insufficient. A surviving party, P.O.D. payee or beneficiary who receives payment from a multiple-party account after the death of a deceased party shall be liable to account to his personal representative for amounts the decedent owned beneficially immediately before his death to the extent necessary to discharge the claims and charges mentioned above remaining unpaid after application of the decedent's estate. No proceeding to assert this liability may be commenced unless the personal representative has received a written demand by a surviving spouse, a creditor or one acting for a minor or dependent child of the decedent, and no proceeding shall be commenced later than two years following the death of the decedent. Sums recovered by the personal representative shall be administered as part of the decedent's estate. This section does not affect the right of a financial institution to make payment on multiple-party accounts according to the terms thereof or make it liable to the estate of a deceased party unless before payment the institution has been served with process in a proceeding by the personal representative.

I hereby acknowledge that I have received a copy and understand the provisions of SDCL 33A-4-16, 33A-4-17, 33A-4-18, 33A-4-19, 33A-4-20 and SDCL 29A-6-107 regarding the state's preferred claim for maintenance payments of deceased members.

_____ _____

Applicant's Signature Date

_____ _____

Signature of Next of Kin/Witness Date

Michael J. Fitzmaurice South Dakota Veterans Home
Preliminary Financial Disclosure
(605)745-5127

The Veterans Home **NCU/SCU area** operates under Medicaid guidelines.

The **Independent Living Household** operates under South Dakota Veterans Affairs Administrative Rules defined by South Dakota Codified Laws which determine your monthly fee. It is important to remember that this fee is reviewed annually and can change based on changes in your gross income and asset status, operating cost of the Home, and changes in Administrative Rules. Initial Maintenance Rent will be based on current income (and assets), or on Adjusted Gross Income from your prior year's Federal Income Tax Return (and assets), whichever is greater. Annual updates to your Financial Statement are required.

1. INSTRUCTIONS:

Read this form carefully and follow all instructions throughout the form.

1. The following documents are required with your application. Attach copies of:

- **previous three (3) years of federal tax returns unless you have a 70% or higher VA compensation rating**
- **the last three months bank statements for all accounts unless you have a 70% or higher VA compensation rating**
- **most recent VA pension/disability award letter**
- **your most recent Social Security Award letter**
- **any other income and asset documentation**
- **previous Medicaid letters from Dept of Social Services**

2. Include copies of all required documents. DO NOT ATTACH ORIGINAL DOCUMENTS.

3. You are required to provide this information before an interview will be scheduled.

If you have questions about completing this section or need help, please contact the Business Manager or Admissions Coordinator at 605-745-5127

If someone else is filling out this form, provide the following information for the individual completing the form.

Name:		
Address:		
City:	State:	Zip:
Phone number (including area code):		
Relationship to applicant		

1. SPOUSE INFORMATION (whether or not spouse is moving in)**:**

Spouse's Name	Birth date	Sex	SSN

2. INFORMATION ON DEPENDENTS:

Dependents Name(s)	Birthdate(s)

3. LIVING ARRANGEMENTS: Check the box that describes current living conditions

Self:	◯ Own Home	◯ Renting	◯ In someone else's Home	Other (describe)
Spouse:	◯ Own Home	◯ Renting	◯ In someone else's Home	Other (describe)

4. INFORMATION ON MEDICARE:

Attach copies of Medicare card(s), front and back, if you or your spouse have Medicare.

Do you have Medicare? ◯ Yes ◯ No	☐ Part A	☐ Part B	☐ Part D	Effective date(s)	Medicare ID Number
Does your spouse have Medicare? ◯ Yes ◯ No	☐ Part A	☐ Part B	☐ Part D	Effective date(s)	Medicare ID Number

5. INFORMATION ON MEDICAID:

Attach copies of Medicaid card(s), front and back, if you or your spouse have Medicaid.

Do you have Medicaid? ◯ Yes ◯ No	Medical ☐	Long Term Care ☐	Effective date(s)	Medicaid ID Number
Does your spouse have Medicaid? ◯ Yes ◯ No	Medical ☐	Long Term Care ☐	Effective date(s)	Medicaid ID Number

6. INFORMATION ON ALL OTHER INSURANCE: If you have other insurance, please complete the following information and provide copies. This includes health, long term care, and prescription medication coverage. Attach another sheet if more room is needed.

Insurance Provider Name and Address	Annual Premium	Type: Hospital, Medigap, Rx, etc.	Effective Date(s)	Policy Number
Self				
Spouse				

7. INCOME AND EARNINGS:

List all types of earnings and income that you, your spouse, or dependents receive.
List the income amount before deductions (such as taxes and insurance) are taken out.
Include proof of all income (check stubs, bank statements, benefits letters, etc.)
Make copies, do not send the Original Documents.

Examples of income include:

*Social Security	*Social Security Income	*Wages/Self Employment	*Annuities
*Railroad/Retirement Benefits	*Veterans Benefits	*Trust or Annuity Payments	*Long Term Care Benefits
*Pension/Retirement Benefits	*Rental Income	*Oil Royalties/Mineral Rights	*Disability Income

Who Receives Income Self/Spouse	Type of Income	Amount	Source of Income	How often Received?	ID Number (if Req)

8. ALL ASSETS:

Do you or your spouse own all or part of any Real Estate? ◯ Yes ◯ No
If yes, please complete the following for each piece of real estate.

Address	Value	Amount Owed

Do you or your spouse, own a Car, Truck, Motorcycle, Boat trailer, or other vehicles? ◯ Yes ◯ No
If Yes, please complete the following information about each vehicle

Owner(s)	Year	Make	Model	Value	Amount Owed

9. ALL ASSETS:

List all types of assets owned by you or your spouse. Include any accounts or properties on which your name or your spouse's name appears. Include verification (such as copies of your most recent bank statement, trust fund statements, etc.) of all resources. Examples of resources:

* Checking accounts
* Savings accounts
* Government bonds
* Trust funds
* Funeral plans/burial arrang
* Burial Plots
* Stocks and Bonds
* Certificates of Deposit
* Cash on hand
* Safety Deposit boxes
* Retirement Funds
* Other Income, Resources
* Annuities
* Life Insurance

Attach additional pages if needed.

Type of Resource	Account/Policy #	Value	Name & Address of Bank, Insurance Company or other Financial Institution

10. STATEMENT OF PROPERTY TRANSFERS:

I have ◯ (or) have not ◯ sold, transferred or conveyed any property or other assets within the last five (5) years

If so, to whom:

Name: _____

Address: _____

Phone #: _____

Description of the property or assets:

Value of the property or assets: _____

Amount received: _____

Disposition of the proceeds:

11. APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT: I understand that, by signing this application, I am agreeing to a review of my eligibility by state officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my financial information. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary verification. I authorize the use of my (our) Social Security Number's) for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify my financial status.

12. OPTION TO PAY FULL COST OF CARE: I hereby choose and agree to pay the full cost of care in lieu of providing my financial information and documentation. I further understand that the current maintenance rent for the proposed level of care is currently _____per month, and that this is recalculated on an annual basis according to the Administrative Rules of South Dakota. (Further details provided upon request) Full signature is also required below.

13. APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN: State law provides for fine, imprisonment, or both for any person who withholds or gives false information. I understand the questions on this application, and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I also agree that during my stay at the Home neither I nor any agent of mine will transfer any of my assets to avoid payment for my care, or if any amount is still owed based on the full cost of my care at the time of my death. I agree to notify the SDVH of changes in my income, resources, or assets which might affect my maintenance rent at the MJ Fitzmaurice SD Veterans Home.

14. MEDICARE PART B & D: If I do not have Medicare part B and D upon admission, I agree to apply for both during the next open enrollment period.

15. MEDICAL RECORDS: Medical records will be obtained via the attached medical records Release of Information (ROI) forms on pages 11-13. If your received records do not contain a History & Physical or annual exam within the last 60 days proceeding the date of the application you may be required to schedule an appointment with your primary care provider for a History & Physical or annual exam.

_____ _____

Signature of Applicant or Representative (REQUIRED) Date

_____ _____

Signature of Applicant's Spouse Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM NON V.A. PROVIDERS

Name_____ Date of Birth _____

Medical Record Number_____ SSN: _____

I Hereby Authorize (name of person or facility sending information)_____

_____

to release my health information to: *Michael J. Fitzmaurice South Dakota Veterans Home 2500 Minnekahta Ave. Hot Springs, SD 57747*

Information to be released (check each requested item)

☐ **History and Physical** ☐ **Progress Notes** ☐ **Soc. Worker Notes**

☐ **Laboratory Reports** ☐ **Radiology Reports** ☐ **Entire Record**

Other: (Please specify):_____

The following information will not be released unless you specifically authorize it by checking the relevant box (es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment

☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment

The purpose of this release is (check one or more)

☐ Continuity of care; Assessment for admission; Treatment; Discharge planning

☐ At the request of the resident/resident's legal representative

☐ Other (state reason) _____

NOTICE: Michael J. Fitzmaurice South Dakota Veterans Home and many other organization and individuals, such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect it.

MY RIGHTS:

I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

I may revoke this authorization at any time, provided that I do so in writing and submit it to the Michael J. Fitzmaurice South Dakota Veterans Home at 2500 Minnekahta Avenue, Hot Springs, SD 57747. Any information disclosed prior to receipt of written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under authorization in any form or medium, including oral, written, or electronic transmission.

I am entitled to receive a copy of this Authorization.

Expiration of Authorization

Unless otherwise revoked, in writing, this authorization expires at the time I am no longer a resident at the Michael J. Fitzmaurice South Dakota Veterans Home.

_____ _____

Signature of Resident or Legal Representative Date

_____ _____

Printed Name Legal Representative Relationship

_____ _____

Witness Date

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

VA BHHCS
500 N. 5TH ST
HOT SPRINGS, SD
57747

or

VA BHHCS
113 COMANCHE RD
FT. MEADE, SD 57747

or

SIOUX FALLS VA HCS
2501 W 22ND ST
SIOUX FALLS, SD 57105

or

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Michael J. Fitzmaurice South Dakota Veterans Home
2500 Minnekahta ave
Hot Springs, SD 57747
605-745-5127 x 1500115 medical records fax 605-745-5507

PURPOSE(S) OR NEED: Information is to be used by the individual for:

☒ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☒ HEALTH SUMMARY *(Prior 2 Years)*

☒ INPATIENT DISCHARGE SUMMARY *(Dates)*: LAST 2 DISCHARGE SUMMARIES

☒ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☒ DATE RANGE: LAST 6 MONTHS OF ALL PROVIDER NOTES, LAST 1 MONTH OF NURSING NOTES

☒ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☒ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☒ DATE RANGE: LAST 6 MONTHS OF LAB TESTS

☒ RADIOLOGY REPORTS *(Name & Date)*: LAST 6 MONTHS OF RADIOLOGY REPORTS

☒ LIST OF ACTIVE MEDICATIONS: _____

☒ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☒ OTHER *(Describe)*: DEMOGRAPHICS/FACE SHEET, ALL VACCINATIONS, ADVANCED DIRECTIVES, POA, SOCIAL WORK INITIAL ASSESSMENT AND PROGRESS NOTES LAST 6 MONTHS, MENTAL HEALTH EVALUATIONS/TESTING/PROGRESS NOTEES, PT, OT, ST NOTES, NUTRITION NOTES

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire.

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): UPON WRITTEN REVOCATION OR DISCHARGE FROM THE MICHAEL J FITZMAURICE S.D. VETERANS HOME

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY: